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REMARKS

—ON—

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SAINT LOUIS.

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We have to thank Dr. Maughs for having presented to this Society on Saturday night last, an able paper, in which were elaborately discussed certain points in the pathology of Syphilis, and touching which, I ask permission to makesome reply.

The subject of syphilis is always a deeply interesting one, not only because every point and phase in regard to it has been a bone of scientific contention, but from the further fact that its formidable aud horrible character concerns directly or indirectly every member of the human family. Not only does it visit the sins of the parent upon the third and fourth generation, but its innocent victims are perhaps far more numerous than generally supposed. It is our duty as physicians therefore, to weigh well every question appertaining to its pathology and treatment, that we may carefully and conscientiously sift every grain of truth from the vast amount of literary chaff, which from first to last has accumulated in the discussion of this subject.

Without going back to the views of the earlier writers on syphilis, we will confine ourselves to a review of the points mooted by Dr. Maughs in his paper. Before doing so, however, let us briefly take our bearings, and survey the common ground on which we stand.

For practical purposes, the study of syphilis may be divided

into two epochs,—the dividing line being drawn only one generation back, when Bassereau first established the important fact, that there are two distinct kinds of so-called venereal ulcer; — the one carrying with it constitutional taint, whilst the other is simply a local lesion. The diagnostic distinctions between these two kinds of sore, clouded as they are, at times, with perplexities and difficulties — so fully treated of in the books — do not at present concern us. Suffice it to say, that it is a clinical fact, accepted by all observers, that constitutional symptoms do not follow a minor proportion of venereal lesions. Under the light of this new revelation, together with numerous clinical observations and enlightened experiments, conducted under improved hospital advantages, the present generation has lived to see theoretical dogmas gradually give place to crystalized facts, the result of which has been to reduce chaos to a semblance of order, and establish the fact, that syphilis, like all else in nature, is subject to a *reign of law.*

I presume, all of us will admit, that a true chancre, that is to say, the primary lesion of syphilis, is: (1) invariably the result of syphilitic inoculation; (2) that it always develops after a period of incubation of from two to six weeks, during which time the point of inoculation heals; (3) that one attack of syphilis, like that of variola or measles, imparts immunity against a second, — hence it is not auto-inoculable; (4) a true chancre is invariably followed by constitutional symptoms, — generally within from one to three months after the primary sore; (5) that constitutional manifestations, when undisturbed by medicine, constitutional diathesis, or inter-current accidents, follow a certain law of evolution.

In assuming the truth of these propositions at the outset of our argument, I may be a little premature, for perhaps Dr. Maughs may dissent from the assertion, that "the primary lesion of syphilis is invariably the result of syphilitic inoculation," since, as I understand him, he contends, that a chancre can *only* arise from the contagion of a chancre, while the contagion of a secondary accident invariably begets — after its kind — a secondary accident. In other words, Dr. Maughs contends, that when a person contracts syphilis from another, he takes up the thread of the disease just at whatever stage he finds it, and spins it out to the end; if he happens to stumble on a chancre, he gets a chancre; if he comes in contact with a secondary

accident, it is — to use the Doctor's own words — transmitted *"in kind"*; should this prove to be a mucous patch, he contracts a mucous patch; if a papule — a papule, and so on down to the end of the chapter. This law, if it be a law, is certainly a matter of great practical importance, for it would then behoove every victim of syphilis to send his doctor forthwith to the propagator of the disease, in order to ascertain the exact stage to which it has reached, thus enabling him to predict with some certainty what might be still in store for his patient. It would be fatal to Dr. Maughs' argument to attempt to evade this practical deduction, for apart from the well-known clinical fact, that syphilis never retrogrades in its course, but advances through successive stages of evolution; it would never do — from his standpoint — to admit, that a *late* secondary accident could beget an *early* secondary accident, for if matter from a *rupia* or *ecthymatous* ulcer, could by any possibility give rise to a *roseola*, then why not admit, that it can take just one step backward and produce a *chancre*, for after all a chancre is as much constitutional syphilis as any of its sequelæ.

Instead of viewing syphilis in its totality, as one disease, passing through various phases, from incubation to its final termination, Dr. Maughs represents its several stages as so many distinct affections, each generating disease after its kind :—a sort of morbific *tapeworm*, so to speak, with each segment posessing individual procreative power! Such an anomaly as this would be without a parallel in the history of diseases, many of which convey a contrary teaching, for every one knows, that when a patient is infected with smallpox, the disease goes through its full course — *ab initio*, irrespective of the stage of the affection from which it was contracted, and the same may be said of all the exanthemata, between which class of diseases and syphilis, by the way, there are many striking analogies. Indeed we may say, that we have always regarded it a misnomer to call syphilis a venereal disease, for the reason, that there is no proof that it is essentially venereal in origin, and we know that it is not necessarily so in its propagation. The reasons why syphilis is generally communicated in the venereal act, are too self-evident to need recital, suffice it to say, that the anatomical and physiological relations of the generative organs render them incidentally the most frequent media of contagion between the sexes, and this very fact should convince us that however plaus-

ibly a few, even distinguished, men of a past generation may have theorized in regard to the transmission of secondary syphilis, as such, yet overpowering clinical evidence, within the daily reach of every physician, teaches directly the contrary. For we all know, as Dr. Maughs and Baumler affirm, that "condylomata are the most frequent source of syphilitic contagion", and for the reason that they are chiefly confined to the region of the genital organs, especially is this the case with females. The late Dr. Thos. Kennard in a very able paper on the subject of syphilis, read before this society in 1878, gives it as his experience in a large venereal practice, and as one of the medical examiners under the *Social-Evil Law*, that "*most prostitutes suffer from syphilis early in life.*" And while their chancres heal within two months, their secondary symptoms last at least two years. Now, according to Dr. Maughs' theory, these women would only have an opportunity to impart a chancre for from three weeks to three months of their lives, while they are capable of transmitting secondary syphilis for a period of from two to five years. In view of these facts, and if secondary syphilis were only transmissible as such, would not secondary syphilis (as the initial stage) become the rule with men, while chancre would prove the exception? Now I would ask the Doctor how many cases he has met with in which a "secondary accident" was the initial lesion? Is it not plain to every mind that if there were any such law as the Doctor supposes, that every member of this society could rise in his place and recite cases by the score from his practice? Yet I will venture to say, that there are very few who will say, that they ever even imagined that they had met with a single confirmatory example.

The fact is, that when a patient comes to us with secondary syphilis we all, intinctively, go back to the beginning of the trouble—to *the chancre.* And, if he does not volunteer the information, we naturally inquire with reference to the former existence of a chancre, and with the *rarest exception* we find no difficulty in tracing the disease to a chancrous origin. Such is the universal practice and such is the universal clinical experience. It does seem to us, that such preliminary considerations as these, ought to convince even the most skeptical that there can be no real foundation for such a law of contagion in secondary syphilis, as Waller and his colleagues support.

But, as already remarked, these questions are of great practical moment, and one ought to try them with all the circumspection and fairness that should characterize a Court of Justice. As jurors in the case we should carefully sift all the evidence, both circumstantial and otherwise, that we may render a true verdict. Dr. Maughs has already introduced the testimony in support of his side—concerning portions of which we shall have something to say after a while. In addition to the circumstantial evidence already adduced in support of our position, we would introduce some incontestible facts from our own clinical experience, wherein it was proven beyond a doubt that gennine chancres were contracted from secondary lesions. During my residence in Parkersburg, W. Va., there lived there a young girl of uncommon beauty, who while still under the maternal roof and wearing every outward semblance of respectability, was known among the young men as a prostitute. I treated this girl for secondary syphilis. On first coming, she informed me that she had had a chancre some months back, which had healed. She was under my observation for several years, and being of a delicate constitution, together with carelessness in taking remedies, caused the disease to go rather hard with her. She suffered with repeated attacks of mucous patches, and condylomata for fully two years. During this time, not less than a half dozen young men came to me with chancres which they said had been contracted from this same girl, all of which were followed by the usual phases of syphilis. I might mention other intances almost as conclusive, but cite this case because it occurred in a small town, where I had every opportunity to become conversant with the facts, and to satisfy myself that they were facts. I will venture to say that there are physicians in Parkersburg now, whose experience would verify my own.

It is unnecessary to quote in detail the cloud of witnesses of the highest authority who bear unequivocal testimony to the fact that when syphilis is inoculated into the system of a person previously healthy, it goes through the usual stages, beginning with the primary ulcer or chancre, and this, without regard to the source or stage of the virus from which it is derived. Even the contagion derived from hereditary syphilis proves no exception to this rule, which is vouched for by all the leading syphilographers of the present day. Dr. Dron (*Annales de Dermatologie et Syphilographie*, No. 3, 1870), furnishes a striking array

of examples proving the transmissibility of poison from a syphilitic infant to a healthy nurse, producing in each instance a chancre on the nipple.

The following is a condensed abstract taken from Ranking, January 1871. "A nurse, previously in good health, suckled for a time a syphilitic infant. After this child had been removed she remained free from disease for a long time, and then another child, in perfect health, was given her to suckle. During this latter process, without the woman having been exposed to a fresh contagion, there was developed upon her breast a syphilitic chancre, which was transmitted to the other infant confided to her care. These facts are explained by the duration of the incubation, which may extend beyond a mean time of twenty-five days, and reach over a period of six weeks or some two months. The Author quotes in proof of this two series of observations; in the first, comprising twelve cases, the mammary chancre presented itself at a more or less remote period from the cessation of suckling, and the nurses during this stage of apparent health have been enabled to take charge of a second child. In the second series, comprising five cases, the nurses, after the death of the syphilitic child, have taken another in charge, and the syphilitic chancre developed upon them during suckling has been transmitted to the child."

In discussing hereditary syphilis, Dr. Maughs seeks to confound those who insist on the invariable presence of a primary sore, by asking where this sore is located in the product of conception. "Is the chancre upon the ovum, the germ-cell of the mother, or upon the spermatozoon, the sperm-cell of the father?" For, continues he, "It must be upon one, or the other or both, if constitutional syphilis can only be derived from a lesion of continuity, a primary sore, a chancre." Now we admit that this proposition is, what doubtless Dr. Maughs intended it to be—a *reductio ad absurdum*, but, would suggest that the *absurdity* rests not with the side upon which it was intended to be placed. The answer is, that the primary lesion in this case was located somewhere upon the body of the father, or mother, or both, through which, either the germ-cell or the sperm-cell, or both, were already contaminated before entering the womb, hence the name, *hereditary* syphilis. The germ-cell of the mother and the sperm-cell of the father, at the moment of coming together in the act of conception, are as essentially deriva-

tives of their own respective bodies as they were before leaving the ovary of the one, or the testicle of the other. Constitutional syphilis exists in the germ-cell or sperm-cell, as the case may be, at the moment that it is evolved from the blood of the parent, and is thus—to use the expressive language of Fournier—transmitted "*ready made*" to the offspring. There is no analogy to the inoculation of a new and healthy being in this case, and it would be as absurd to contend that the fœtus was *inoculated* with syphilis in the act of conception, as it would be to say that a boy was *inoculated* with a red head by his father, or a freckled face by his mother!

But, following the teachings of an extinct school of syphilographers, who entertained confused and notoriously erroneous views in regard to the pathology and treatment of primary syphilis, Dr Maughs contends that the product of inoculation with matter from a secondary accident—even at the point of insertion—is never a chancre, but essentially a secondary lesion.

This brings us to a point where it becomes necessary to have some distinct understanding in regard to terms. In the literature of no other disease has there been such confusion of nomenclature as in that of syphilis, and to this fact are due many of the disputes that have arisen in reference to its pathology. In the first place we must come to a clear understanding as to *what is syphilis*, and secondly as to the essential difference between primary and secondary syphilis. In other words, we must agree upon what constitutes—as we call it in this country—a chancre, or primary lesion, in contradistinction to what is known as secondary syphilis. Some employ the term *constitutional syphilis* as a synonym for either the secondary or tertiary form of this disease; but it may well be doubted whether this is pathologically correct, since a true chancre, or infecting sore, is itself an evidence of constitutional contamination, that is to say, the virus has already entered the general system during the development of the local sore, which lesion is the first link in a chain of phenomena constituting the essentially constitutional disease—syphilis. In recognition of this fact, writers, especially among the Germans, have discarded the term chancre altogether as applicable to the initial lesion, reserving that name for what we denominate chancroid, while the constitutional disease syphilis receives this simple designation and no other. Any one who will turn to Niemeyer (Vol. II p. 677) will see that he

adopts this nomenclature, nevertheless this author remarks that "as the first sign of constitutional infection always appears in the form of an ulcer or induration at the point of entry of the virus, the terms 'primary induration' and 'primary sore' may be regarded as perfectly appropriate." But it will be perceived that this distinguished pathologist makes only a technical distinction between primary and secondary syphilis, the two being regarded only as different phases of one disease, the normal history of which is characterized: first, by a certain point of inoculation; second, a period of incubation; third, the development and maturity of a lesional manifestation; fourth, after a second period of apparent latency, the evolvement of other lesions more or less general and variable according to circumstances, but which pursue general recognized laws of development. Clinically, these different phenomena are links in *one chain* of events, and are designated as *secondary* because it is understood that they invariably result from a *primary* source. Fournier the great pupil of Ricord, has happily compared the rise and progress of syphilis to a *drama*, subdivided into a series of acts and inter-acts, as follows:

"First act. *Contamination;* the virus penetrates by a certain proceeding into the organism.

"First inter-act. Apparent repose of the organism. *Incubation.* No appreciable indication of the disease yet presented.

"Second act. Formation at the point where the virus has penetrated, and at this point only, of a lesion called the *primary affection*, which constitutes at this moment the *unique expression* of the disease.

"Second inter-act. Fresh apparent repose of the organism. *Second incubation.* The primary lesion still remains the *sole* phenomenon by which the infection is manifested.

"Third act. Explosion of multiple and dessiminated symptoms beyond the seat of contagion, the so-called *consecutive* or *secondary* symptoms. This is the period of the apparent *generalization* of the disease."

Now let us briefly examine the testimony adduced by Dr. Maughs in support of the idea that the inoculation of secondary lesions invariably produces not a chancre, but secondary syphilis. This evidence consists of extensive citations from the writings of

Vidal, Waller, Wallace, Parker and their followers, who forty years ago fought and won the great battle with Ricord and his school, touching the contagiousness of secondary syphilis,—a defeat which the latter has gracefully acknowledged, and now there is no one to be found who will seriously deny such communicability. The only question remaining in regard to this subject (in the minds of a few) is whether secondary syphilis is transmitted "*in kind*", whether the point of inoculation develops into a "secondary accident," or a chancre. Almost the universal sentiment of the profession of the present day is that the lesion thus produced is a *chancre*,—that it is the first act in the drama of Fournier, and that the disease pursues practically the same course as though it had resulted from a chancrous inoculation. In denying that such lesion is a chancre in all its essentials, the unanimous verdict is that Vidal and his colleagues, while promulgating a great practical truth, have gone too far and fallen into error, an error resulting from the imperfect views of their day as to the pathological anatomy of the primary lesion of syphilis. No one can peruse the writings of these distinguished surgeons without admiring the energy and zeal with which they wrestled with the great question of their time, but at the same time he will be struck with the incongruities and crudities of their pathology. Nor can this be wondered at, when we remember that at this day no definite distinction had been drawn between what is now known as chancroid and true chancre. Practically, all venereal sores were considered as essentially the same. The deeper and uglier looking the lesion, the more solicitous they were for the consequences, and the more destructive and heroic the measures resorted to, in order to *burn out* (as they said) the virus, before it should impress the system. Not a few of this school went so far as to include gonorrhoea and balanitis in the category of syphilis, and to ascribe to them constitutional sequelæ. With such an immature basis to work upon, it is not surprising that the history of their observations should be imperfect and inconclusive. Moreover, their experiments consisted mostly in auto-inoculations, and as they employed for this purpose, indifferently, matter from chancroid or chancre, the results are purely negative and utterly worthless.

Nor are the few experimental inoculations and cases cited by Dr. Maughs by any means conclusive in establishing his views.

Had Waller, Vidal and Wallace given any evidence that they fully appreciated the nice clinical distinction, now so thoroughly recognized and established, in regard to the modifications of chancre, their testimony would be entitled to much more weight. But as it was, they regarded the deep abruptly excavated ulcer as the typical chancre. So that even accepting literally their own phraseology in describing their experiments, the conclusion is irresistible that the result of their inoculations with secondary matter was the production of a primary sore, and not secondary syphilis. Take Waller's case, for example, where he scarified the skin of a healthy boy and applied to the cuts the secretion from a mucous tubercle. By the fourth day the wounds had healed, and so remained until the 28th day, when tubercles and papules appeared at each point of inoculation. Without detailing the subsequent history of this experiment, Dr. Maughs exclaims: "Here we see it was the secondary accident, the tubercle, that was transmitted." Why? What evidence is there here of a secondary lesion? Has not a sore manifested itself at each point of inoculation and *no other*, after a period of incubation of twenty-eight days? Are not the local lesions in the shape of papules and tubercles? Would any of these phenomena have been different, had the inoculation been direct from a chancre? If so, in what respect? True, the natural history of chancre is, that it is usually single, but this does not apply to artificial inoculation, where the virus is introduced simultaneously at several points. Were genuine chancrous virus applied to a blistered surface, the inoculation would cover the area of the blister, so that it might be possible to secure an artificial chancre the size of a dinner-plate, but it would be none the less a chancre on that account. In the case of Waller, under consideration, the instrument employed was a scarificator, and had matter from a genuine primary chancre been used, there would have resulted fourteen little red tubercles, papules or nodules, appearing about the 28th day, answering to each blade of the instrument. These would probably have coalesced into a larger sore, finally healed, and been followed by general constitutional symptoms precisely similar to those that actually occured in the experiment as detailed.

Let us suppose that genuine chancrous virus is introduced by means of a lancet-thrust into the integument of a healthy person, what are the phenomena that might be expected to follow?

We give the answer in the words of that accurate observer, Niemeyer (Vol. II. p. 678). Here is what he says: "After inoculation of a suitable subject with syphilitic virus, whether accidental or intentional, that is to say, of a subject who is not syphilitic, and who has never been so, and after expiration of the term of incubation, there arises, *not a vesicle nor pustule which breaks*, leaving a sore, but a hard papule or nodule of variable size and thickness. The smaller syphilitic indurations are the size of a lentil or pea; the larger attain the size of a bean or a small hazel-nut. * * * * The epidermis, or epithelium, over this hard infiltration, at first does not exhibit any lesion; but soon the epithelial covering begins to exfoliate, the new coating becomes thinner, the surface shows a peculiar glittering, dirty redness, and, after repeated exfoliation, the epithelium is not renewed, but the surface remains raw, and gives off scanty secretion. In other instances the surface forms a scab, which, after separation, leaves an ulcer with a hard base." Could any description answer more perfectly to Waller's case, just cited, than this graphic picture of Niemeyer's?

Again this author, in speaking of the varieties of chancre, thus describes a not uncommon one, known as the *elevated* sore. He says: "It presents an excoriation which is almost void of discharge, seated upon an indurated base of varying thickness and consistence, by which it is elevated above the surrounding level. From time to time it is coated with a thin layer of epithelium, which generally soon exfoliates in fine scales, leaving a new excoriation." Such a lesion as this would probably have been denominated a "*mucous tubercle*," and not a *chancre*, by Waller; for instance, he once had a nurse in the venereal hospital at Prague, who became affected by suckling a syphilitic child. He published the case, and described the lesions on the nurse as *mucous tubercles*; he stated that the one on the right breast was the size of a bean; that on the left, of a pea, and that both rested on a broad base. Ricord, in commenting upon this case, says: "I know, not what may be regarded as mucous tubercles at Prague,—but at Paris those described by M. Waller would be considered as very excellent specimens of indurated chancre with a broad base!"

We will not consume your time by going into a minute review of all the experiments and cases cited by Dr. Maughs, but can

not forbear mentioning one other, for the reason, says the Doctor, that it is "one of the most interesting, as well as best observed and authenticated cases of the communication of secondary syphilis." We allude to the student Boudeville who was inoculated by Vidal with pus "taken from two ecthymatous ulcers."

Now we think we shall be able to convince, even as tenacious an individual as our worthy President, that the history of this experiment is absolutely fatal to his argument; it not only disproves *his* theory, but it offers the most convincing testimony in support of *our* position; let us analyze it a little.

On the 28th of Oct., 1849, there entered Vidal's hospital a servant aged 23, with well marked secondary syphilis following a chancre of the penis, in addition to mucous tubercles, cephelalgia etc., the chest and the abdomen were covered with suppurating papules. On the 28th of Oct. (the day of admission) punctures with a lancet charged with pus from one of the pustules on the the right side of the chest were made on the thigh of this same patient. On the 29th (next day) "an elevation appeared at the points of puncture, which gradually assumed the character of the pustules on the trunk." Here, says the Doctor, we see again that the "transmission was in kind." Well, we are willing to accord Dr. Maughs all the consolation he can get out of this experiment; we not only freely admit, that secondary syphilis was here transmitted "as secondary syphilis," but also congratulate him that he has proven to our entire satisfaction that a man can have the same "*kind*" of secondary syphilis on his leg that he has on his belly! In short, this was an auto-inoculation, and therefore, like thousands of other experiments instituted about the same time, utterly worthless. Here the patient was already saturated with syphilis and the prick of a lancet on the thigh very naturally and promptly took on a papulous character similar to others upon other parts of the body.

But, to continue with the next step in this experiment. Matter was again taken from this induced papule and introduced elsewhere upon the thigh of the same person, with the same result as before. "Now," exultingly exclaims Dr. Maughs, "it will be noticed that secondary accidents were not only twice transmited in this patient, but were each time transmitted of like character"!

We pass to the third step in this experiment wherein, matter

from one of the papules on the chest of this same patient was inoculated into both forearms of a non-syphilitic subject, the student Boudeville. It will be observed that in each of the auto-inoculations upon the thigh of the first patient, the effect was almost instantaneous; on the *next day* papules commenced to form, which ran their course from thence onward. Let us compare this with the result of inoculation in a fresh subject. M. Boudeville was inoculated on the 1st of Nov.; on the next day traces of inflammation began to appear, with pain in the part, which resulted in a local pustule similar to what we observe after a spurious vaccination; *this healed by the 15th day*, leaving a scaly cicatrix. We let M. Boudeville describe the further progress of his case in his own words. He writes: "Such were the condition of things until the 5th of December, thirty-five days after the inoculation, at which time a change occurred; an inflammation supervened, and two consecutive pustules appeared, occupying precisely the situation of the first, and I suffered a severe pain in the same locality." He further says that cicatrization of this sore was very slow not being completed until the 20th of January 1850—*forty-five* days. After this there was no symptom of any further trouble until April, when Boudeville makes the following note. "About the 25th of April I experienced some difficulty in swallowing, and the mouth began to inflame: a roseala appeared on the body which lasted three or four days, and finally mucous tubercles became developed on the pillars of the palatine arch, followed by rheumatic pains, nocturnal cephalalgia etc."

We see in the foregoing case a fair illustration, an absolutely typical development of syphilis, all the acts and inter-acts in the "drama" of Fournier, played fairly and fully. We again ask Dr. Maughs in what respect would this patient have been differently affected, had he been inoculated directly from a chancre. Does he answer, "In the appearance of the primary lesion?" If so, let me remind him that there are a great many varieties of chancre, so many indeed, and modified by so many circumstances, that even the most astute observers are frequently puzzled as to the real nature of any given lesion. Experience and the teachings of authority have taught us much that is positive, and also a good deal that is negative; experience is valuable in that it gives us wisdom, and wisdom often strikes at the root of self confidence .This is evidently true in the diagnosis of syphilis,

the primary lesion of which is usually met with on the genitalia. Most of the descriptions of chancre, in the books, refer to their appearance when thus situated, and even under these circumstances, we know how uncertain and difficult it is always to make a positive diagnosis and prognosis. In many cases we have to depend on time to clear up our doubts; time is the grand arbiter in this matter, and none appreciated this more keenly than Vidal, Waller and their associates. Try their inoculations of secondary syphilis upon healthy subjects by this test, and the conclusion is inevitable that the result in each case was a *chancre*, followed in due course by secondary symptoms.

From the necessity of the case, the behavior of a sore arising from artificial inoculation is rarely seen, but that the lesion created by plunging a lancet, covered with foul pus from a syphilide, into the integument—or by applying the virus to an extensive blister—should be materially different from that contracted through a slight abrasion in the delicate epidermic or mucous membrane of the penis, is not to be wondered at. Again many of these experiments, upon which so much stress has been laid, have been performed upon persons already suffering from grave diseases. In this way Gibert selected for inoculation, patients afflicted with inveterate *lupus*. The well known fact that traumatism frequently interferes with the progress of syphilis, together with the still more remarkable experience of Norwegian surgeons in modifying this disease through the excitation of chronic suppuration of the skin, by means of syphilization and otherwise, would be sufficient to account for slight irregularities presented in the results of some of the experiments dwelt upon by Dr. Maughs. Certainly there is nothing in them however which justifies us in denying that the sore arising at the point of inoculation was to all intents and purposes, a *chancre*; for as understood at the present day, a chancre may be defined as the *initial lesion* of syphilis, and is followed by practically the same sequelæ, whether it results from a primary, or so-called secondary virus.

A few words in reference to one other position taken by Dr. Maughs, and we are through. He says: "The accidents of secondary syphilis may be transmitted from a diseased to a sound person by contact of the secretions without abrasion or lesion of surface, and as a law, such accidents are transmitted in kind." We have sufficiently replied to this proposition, except as regards the point wherein it is claimed that a person may become

infected with syphilis without the intervention of any abrasion or lesion. This is an ancient doctrine, and must necessarily depend upon negative evidence. It is a remarkable fact that such cases nearly always occur in married woman who are not on the alert for syphilis, and with whom a chancre, from its frequent slight development and painless character, might be easily overlooked even by the subject of it. Nearly all married females are liable to slight chafes and discharges, that generally mean nothing, but which might easily mask a chancre.

So far as positive experiments go, they strongly militate against any such probability as is here assumed. Modern researches, as well as clinical experience teach us that the secretion of a syphilitic are not only incapable of communicating the disease by absorption through an animal membrane like the skin or mucous surface, but that they prove inert even when inoculated directly into the blood. Pellizzari, through his experiments, has conclusively proven that syphilis is only communicable between individuals by means of cells or albuminoid molecules derived from an active syphilitic lesion, and since these can only effect an entrance into the system through a breach of continuity, there can be no such thing as the "physiological absorption" of the virus. Even the pure lymph of a vaccine vesicle, when free from blood corpuscles is said to be devoid of poison These facts are so well vouched for that it is needless to cite authority.

In regard to the absorption of syphilitic virus, Dr. Maughs is somewhat inconsistent, for he cites two cases from his own experience, the first tending to prove that a female can be readily poisoned by the semen of a syphilitic husband, while the second is even more confirmatory of a contrary view. The latter case was the woman he saw with Dr. Cooper, formerly of this city, whose husband was syphilitic, and although cohabitating with him for years and bearing a number of syphilitic children, she remained, according to the doctor's own admission, free from all taint. This is about as conclusive an argument against the possibility of syphilitic absorption as could be made, hence we drop this branch of the subject.

The other case, is that of a lady in which the doctor was called in consultation with Dr. Bryant. This lady was suffering with syphilitic roseola, and the two gentlemen searched care-

fully, and in vain for a chancre, which had probably healed and disappeared many weeks before the nature of her trouble was suspected. A chancre was not to be expected under such circumstances, and it would have been somewhat remarkable had they found one, considering that secondary syphilis had already set in.

The most interesting point in this case, especially in a medico-legal point of view, was the character, or stage of the secondary symptoms, both husband and wife being affected with roseola. That they should both have manifested the same secondary lesions at the same time is not strange, for a woman, when contracting syphilis from a chancre on a man, will often develop secondary lesions as soon, or sooner than the giver, and the two cases subsequently run a parallel course. In this instance, we take it for granted that the lady contracted syphilis from her husband, but the history of his case, as related by Dr. Maughs, is somewhat inconsistent with his symptoms. For, when we see a patient with roseola, followed shortly by congestion of the throat, we are justified in believing that the secondary stage in his disease is just commencing—since these are among the earliest manifestations of secondary syphilis—almost always occurring within three months, and seldom seen later than the eighth or ninth month. The husband confessed that he had in this instance, a chancre "a year or two" before marriage. We will not charge that this statement was untrue, but really the history of the case excites our suspicions. It is barely possible, yea even probable, that this gentleman's memory was a little defective as to dates, and that he contracted that chancre *after* marriage.